

standable, given the relative importance of denominations sharing these convictions in this population, it might cause African-American women of other faiths and belief systems to feel excluded.

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Depression Sourcebook www.omnigraphics.com

Depression Sourcebook is of a very high standard. Its purpose, which is to serve as a reference source to the lay reader, is very well served. The book provides comprehensive and up-to-date information on all the relevant aspects of depression and allied conditions. The content is easy to understand. The language in which it is presented is simple and without technical "jargon".

I have one major criticism of the book—the information provided is extremely repetitive. Chapter after chapter, it repeats the same information, particularly on the causes of depressive disorders and their clinical manifestations, and on therapy. St. John's Wort, an agent of dubious value, is dealt with in several sections, including a separate chapter. Presumably, the reason for this lies in the fact that it is meant as a reference book, and the reader may wish to consult only a chapter or chapters related to his or her particular enquiry. However, this repetition of information has made the book much longer than need be. Surely, appropriate

consultation by the editors with the individual writers and adequate cross-referencing would have resolved the matter!

Some minor points: A brief overview of the spectrum of mental disorders would have been useful, so that the reader could place depressive illnesses in their context. In chapter 3, the psychotic features of depression and mania are not adequately described, making it more likely that the reader may confuse such extreme disorders with other forms of psychosis and will find it difficult to recognize such presentations as a part of the spectrum of manic-depressive disorder.

On page 9, viral illness as a cause of depressive illness is not adequately dealt with.

Cardiotoxicity of tricyclic antidepressants—chapter 32—should have been emphasized, since this is the major danger of overdose of these agents.

The clinical presentation of Schizo-affective disorder is confusing (chapter 9), mainly because the features of schizophrenia are inadequately described.

The dangers of drug administration during the third trimester of pregnancy (page 136), especially just before labor, should have received more attention, especially the possible effects on the parturition process and the neonate. For example, tricyclic antidepressants and carbamazepine may be associated with a dependency syndrome in the neonate.

The eight chapters dealing with deliberate self-harm would have been better integrated into a smaller number of chapters. The risk factors are not adequately dealt with.

Finally, the sections on clinical trials are of doubtful value.

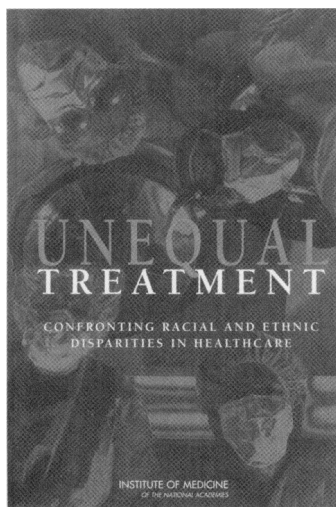
The above criticisms are relatively minor points and do not detract much from the overall value of the book. *Depression Sourcebook* is highly recommended as a reference text for the home and even for the general practitioner's consulting room.

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Unequal Treatment— Confronting Racial and Ethnic Disparities in Healthcare

Hardcover with CD-ROM.
Brian Smedley, Adrienne
Stith, Alan Nelson, eds.
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The legacy of racial and ethnic health disparities consistently reminds patients, health practitioners and policymakers of the unhealthy past of America. Infamous health scandals like the Tuskegee Syphilis Study affect the healthcare choices of both minorities and their providers. Since those infamous days, things have improved—but by how much? Despite passage of the 1964 Civil Rights Act, numerous medical milestones, and the government's "Healthy People" initiative to eliminate minority health disparities by 2010, how close are we in eliminating healthcare disparities among different racial groups?



Dozens of studies, involving tens of thousands of patients, keep finding the same results: blacks and Hispanics, even if they have the same insurance as whites, receive inferior treatment from the healthcare industry.

In heart procedures, cancer treatment, diabetic care, and kidney transplants, most minorities frequently get less. Virtually no one questions the severity of the problem. One astonishing disparity was revealed in a study of 26 million patients, which showed that even when adjusted for income levels to eliminate the differences between poor and rich, blacks were 3.6 times more likely than whites to have an amputation—and 2.4 times more likely to be surgically castrated. The bottom line for all these studies is death. The biggest differences in longevity are found among males: the average black male lives seven years less than the white male's 74.5 years. The average Hispanic male lives five years less.

For more than a decade, such studies have been piling up. They reached a critical mass in 2001. This was when the Institute of Medicine, a research wing of Congress, set up a 15-member

committee to carry out a study to assess the extent of racial and ethnic differences in the quality of healthcare. They were also to provide recommendations regarding interventions to eliminate disparities in healthcare delivery. This book contains a report by this committee. There are 414 pages in book form, while paper contributions are in an attached CD-ROM, comprising pages 417–738.

This book provides ample evidence that racial and ethnic differences in healthcare do occur even when insurance status, income, age, and severity of conditions are similar. These disparities are not benign. They are associated with higher death rates from cancer, heart disease, and diabetes—and therefore, unacceptable. Such differences occur in the context of broader historic and contemporary social and economic inequality. The book also provides evidence of persistent racial and ethnic discrimination in many sectors of American life. The healthcare differences originate from diverse sources, including healthcare providers, health systems, patients, and utilization managers. Prejudice, stereotyping, and bias on the part of healthcare providers may contribute to racial and ethnic disparities.

How do we attempt to “untie” the healthcare disparity knot? Some of the major interventions recommended in this book are as follows:

- Avoid fragmentation of health plans along socioeconomic lines because a disproportionate number of minorities are in the lower end of healthcare plans. The vast majority of doctors agreed, however, that not having health insurance is certain to cause unequal care. Studies generally show that 35–40% of His-

panics, about 25% of blacks and 10–15% of non-Hispanic whites don't have health insurance.

- Increase the proportion of under-represented U.S. racial and ethnic minorities among health professionals. That should be only a first step. The deeper problem is the lack of diversity in healthcare leadership and workforce. Of the senior leaders in healthcare management, 98% are white.

- Provide greater resources to the U.S. DHSS Office for civil rights to enforce civil rights laws.

- Support the use of language interpretation services where the community need exists.

- Integrate cross-cultural education into the training of all current and future health professionals.

- Monitor progress toward the elimination of healthcare disparities.

One's race should not be responsible for one's disease. The concept of “race” has been found to be largely psychological and sociopolitical—rather than biological—as human genome research indicates that all human beings carry 99.9% of the same genetic material regardless of race. If the recommendations outlined in this book are followed, the wide gap in healthcare among the various people groups should substantially diminish.

I highly recommend this book as a vital resource for healthcare policymakers, providers, educators, students conducting research as well as utilization managers.

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